# FOR OHF USE

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# **2002**STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2002)

### IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 0039842	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: CLAREMONT REHAB & LIVING CENTER  Address: 150 NORTH WEILAND BUFFALO GROVE 60089  Number City Zip Code  County: LAKE  Telephone Number: (847) 465-0200 Fax # (847) 465-0400  IDPA ID Number: 36-3976986-60089-0  Date of Initial License for Current Owners: 11/22/94	I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.  Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.
	Type of Ownership:    VOLUNTARY,NON-PROFIT   X PROPRIETARY   GOVERNMENTAL     Charitable Corp.   Individual   State	Officer or Administrator of Provider  (Type or Print Name) BRUCE LEDERMAN  (Title) VICE PRESIDENT
	IRS Exemption Code Corporation Other X "Sub-S" Corp.	Paid (Print Name and Title) (Partner KRUPNICK BOKOR KAGDA & BROOKS, LTD & Address) (Pelephone) (847) 675-3585 Fax # (847 ) 675-5777
	In the event there are further questions about this report, please contact:  Name: BOB KAGDA Telephone Number: ( 847 ) 675-3585	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

	y Name & ID Numb	obinibile:	NT REHAB & LIVI	TIG CETTER			# 0039842 Report Period Beginning: 01/01/2002 Ending: 12/31/2002
I	II. STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/o	certification level(s) o	f care; enter numbe	er of beds/bed days,			(Do not include bed-hold days in Section B.)
	(must agree	with license). Date of	change in licensed	beds			<u> </u>
	( 8	,	8	_	E. List all services provided by your facility for non-patients.		
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
	<u> </u>			<u> </u>	<del></del>		OUTPATIENT THERAPY, MEALS ON WHEELS
	Beds at				Licensed		OUTTAILENT THERAIT, MEALS ON WHEELS
		Τ'		D. J 4 E. J. C			E. D (b. C 224
	Beginning of	Licensu		Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census? YES
	Report Period	Level of	Care	Report Period	Report Period		
							G. Do pages 3 & 4 include expenses for services or
1	200	Skilled (SNI		200	73,000	1	investments not directly related to patient care?
2		Skilled Pedi	atric (SNF/PED)			2	YES NO X
3		Intermediat	e (ICF)			3	
4		Intermediat				4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5		Sheltered C	are (SC)			5	YES NO X
6		ICF/DD 16	or Less			6	
							I. On what date did you start providing long term care at this location?
7	200	TOTALS		200	73,000	7	Date started11/22/94
							J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	the entire report per	riod.				YES X Date 11/22/94 NO
	1	2	3	4	5		
	Level of Care	Patient Days	by Level of Care ar	d Primary Source of	f Payment		K. Was the facility certified for Medicare during the reporting year?
		Public Aid					YES X NO If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified 98 and days of care provided 9,664
8 8	SNF			9,664	9,664	8	
9 8	SNF/PED					9	Medicare Intermediary ADMINISTAR FEDERAL
10 I	CF	22,594	23,369	1,735	47,698	10	
11 I	CF/DD					11	IV. ACCOUNTING BASIS
12 S	SC					12	MODIFIED
13 I	OD 16 OR LESS					13	ACCRUAL X CASH* CASH*
14 7	TOTALS	22,594	23,369	11,399	57,362	1.4	Is your fiscal year identical to your tay year?
	UTALS	44,594	23,309	11,399	57,302	14	Is your fiscal year identical to your tax year? YES X NO
14 1	<del>-</del>						
14   1	C. Percent Oc	cupancy. (Column 5,	line 14 divided by t	otal licensed			Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

	SIAL	L OF ILL	INOIS				Page 3
Facility Name & ID Number	CLAREMONT REHAB & LIVING CENTER	#	0039842	Report Period Beginning:	01/01/2002	Ending:	12/31/2002

	V. COST CENTER EXPENSES (through	hout the report,	please round to	the nearest doll								
		Costs Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	360,017	32,124	22,841	414,982		414,982		414,982			1
2	Food Purchase		313,228		313,228		313,228	(20,952)	292,276			2
3	Housekeeping	224,542	41,381		265,923		265,923		265,923			3
4	Laundry	63,613	10,820	924	75,357		75,357		75,357			4
5	Heat and Other Utilities			219,198	219,198		219,198		219,198			5
6	Maintenance	76,112	17,297	114,046	207,455		207,455	(1,411)	206,044			6
7	Other (specify):*			19,481	19,481		19,481		19,481			7
8	TOTAL General Services	724,284	414,850	376,490	1,515,624		1,515,624	(22,363)	1,493,261			8
	B. Health Care and Programs											
9	Medical Director			56,250	56,250		56,250		56,250			9
10	Nursing and Medical Records	3,085,252	219,850	259,561	3,564,663		3,564,663		3,564,663			10
10a	1 3	594,249	3,662	495	598,406		598,406		598,406			10a
11	Activities	147,592	6,112	44,808	198,512		198,512		198,512			11
12	Social Services	45,252		7,166	52,418		52,418		52,418			12
13	Nurse Aide Training											13
14	Program Transportation			1,091	1,091		1,091		1,091			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,872,345	229,624	369,371	4,471,340		4,471,340		4,471,340			16
	C. General Administration											
17	Administrative	136,517			136,517		136,517		136,517			17
18	Directors Fees											18
19	Professional Services			247,462	247,462		247,462	22,508	269,970			19
20	Dues, Fees, Subscriptions & Promotions			117,289	117,289		117,289	(75,555)	41,734			20
21	Clerical & General Office Expenses	255,475	35,825	79,611	370,911		370,911	(52,143)	318,768			21
22	Employee Benefits & Payroll Taxes			583,621	583,621		583,621	(2,747)	580,874			22
23	Inservice Training & Education			6,861	6,861		6,861		6,861			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			4,309	4,309		4,309		4,309		_	25
26	Insurance-Prop.Liab.Malpractice			131,227	131,227		131,227	14,900	146,127			26
<b>—</b>	Other (specify):*			74,389	74,389		74,389	(74,389)				27
28	TOTAL General Administration	391,992	35,825	1,244,769	1,672,586		1,672,586	(167,426)	1,505,160			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,988,621	680,299	1,990,630	7,659,550		7,659,550	(189,789)	7,469,761			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

# V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			110,448	110,448		110,448	316,909	427,357			30
31	Amortization of Pre-Op. & Org.							14,039	14,039			31
32	Interest			49,867	49,867		49,867	1,070,360	1,120,227			32
33	Real Estate Taxes							182,528	182,528			33
34	Rent-Facility & Grounds			1,560,000	1,560,000		1,560,000	(1,560,000)				34
35	Rent-Equipment & Vehicles			32,981	32,981		32,981		32,981			35
36	Other (specify):*											36
37	TOTAL Ownership			1,753,296	1,753,296		1,753,296	23,836	1,777,132			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		346,476	67,436	413,912		413,912		413,912			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		346,476	176,936	523,412		523,412		523,412			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,988,621	1,026,775	3,920,862	9,936,258		9,936,258	(165,953)	9,770,305			45

<sup>\*</sup>Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

# 0039842

**Report Period Beginning:** 

01/01/2002

Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	In column	1 2 below, reference the		hich the particu	lar cos
	NON-ALLOWABLE EXPENSES	1 Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18,227)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	83,835	30		9
10	Interest and Other Investment Income	(3,140)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,725)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(250)	20		17
18	Fines and Penalties		<b>21</b>		18
19	Entertainment		20		19
20	Contributions	(5,000)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(74,389)	27		24
25	Fund Raising, Advertising and Promotional	(62,360)	20		25
26 27	Income Taxes and Illinois Personal Property Replacement Tax				26 27
28	Nurse Aide Training for Non-Employees Yellow Page Advertising	(7,945)	20		28
29	Other-Attach Schedule	(56,301)			29
	SUBTOTAL (A): (Sum of lines 1-29)	\$ (146,502)		\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

	•
	Z

		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(19,451)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (19,451)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (165,953)		37

<sup>\*</sup>These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

1 2 3

		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Page 5A

### CLAREMONT REHAB & LIVING CENTER

ID# 0039842

Report Period Beginning: 01/01/2002
Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	s 4,349	6	1
2	MARKETING SALARY	(52,143)	21	2
3	MAINTENANCE	(5,760)	6	3
4	FICA	(441)	22	4
5	STATE UNEMPLOYMENT	(92)	22	5
6	FEDERAL UNEMPLOYMENT	(46)	22	6
7	HEALTH INSURANCE	(2,168)	22	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29			1	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48	Total	(EC 204)		48
49	Total	(56,301)	4	49



# 0039842 Report Period Beginning:

Summary A

12/31/2002

01/01/2002 Ending:

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I** 

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER

													SUMMARY	
	Operating Expenses	<b>PAGES</b>	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6 <b>D</b>	6E	<b>6F</b>	6 <b>G</b>	6H	<b>6</b> I	(to Sch V, col	.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(20,952)	0	0	0	0	0	0	0	0	0	0	(20,952)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0		3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0		4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0		5
6	Maintenance	(1,411)	0	0	0	0	0	0	0	0	0	0	( ) )	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	(22,363)	0	0	0	0	0	0	0	0	0	0	(22,363)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	1 3	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0		11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0		12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	1	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0		14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0		17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0		18
19	Professional Services	0	22,508	0	0	0	0	0	0	0	0	0	/	19
20	Fees, Subscriptions & Promotions	(75,555)	0	0	0	0	0	0	0	0	0	0	( / /	
21	Clerical & General Office Expenses	(52,143)	0	0	0	0	0	0	0	0	0	0		
22	Employee Benefits & Payroll Taxes	(2,747)	0	0	0	0	0	0	0	0	0	0	( / /	
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0		23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	1	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0		25
26	Insurance-Prop.Liab.Malpractice	0	14,900	0	0	0	0	0	0	0	0	0	/	26
27	Other (specify):*	(74,389)	0	0	0	0	0	0	0	0	0	0	(74,389)	27
28	TOTAL General Administration	(204,834)	37,408	0	0	0	0	0	0	0	0	0	(167,426)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(227,197)	37,408	0	0	0	0	0	0	0	0	0	(189,789)	29

Summary B Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 **Report Period Beginning:** 01/01/2002 Ending: 12/31/2002

### **SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

													SUMMARY	
	Capital Expense	<b>PAGES</b>	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	<b>6E</b>	<b>6F</b>	6 <b>G</b>	6H	<b>6</b> I	(to Sch V, col.	.7)
30	Depreciation	83,835	233,074	0	0	0	0	0	0	0	0	0	316,909	30
31	Amortization of Pre-Op. & Org.	0	14,039	0	0	0	0	0	0	0	0	0	14,039	31
32	Interest	(3,140)	1,073,500	0	0	0	0	0	0	0	0	0	1,070,360	32
33	Real Estate Taxes	0	182,528	0	0	0	0	0	0	0	0	0	182,528	33
34	Rent-Facility & Grounds	0	(1,560,000)	0	0	0	0	0	0	0	0	0	(1,560,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	80,695	(56,859)	0	0	0	0	0	0	0	0	0	23,836	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(146,502)	(19,451)	0	0	0	0	0	0	0	0	0	(165,953)	45

**Report Period Beginning:** 

01/01/2002 Ending:

12/31/2002

### VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1		2 RELATED NURSING HOMES			3 OTHER RELATED BUSINESS ENTITIES			
OWNERS								
Name	Ownership %	Name	City		Name	City	Type of Business	
BRUCE LEDERMAN	47.50				WINDSOR MGMT		MANAGEMENT	
HAROLD LEDERMAN	47.50				FREEDOM HOME	<b>BUFFALO GROVE</b>	HOME CARE	
ANDREA WEITZBERG	5.0				CARE			
The state of the s								

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES

NO

CLAREMONT REHAB & LIVING CENTER

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	4 5 Cost to Related Organization				6	7	8 Difference:		
									Percent	Operating Cost	Adjustments for		
Sch	edule V	Line	Item	Amount		Name of Related Organization			of	of Related	Related Organization		
									Ownership	Organization	Costs (7 minus 4)		
1	V	34	RENT	\$ 1,560,00	00	WINDSOR I	HEALTHCA	ARE MANA	GEMENT ASSOC		\$	<b>\$</b> (1,560,000)	1
2	V												2
3	V												3
4	V												4
5	V												5
6	V		PROFESSIONAL FEES			WINDSOR I	HEALTHCA	ARE MANA	GEMENT ASSOC		22,508	22,508	6
7	V		DEPRECIATION			11	"	**	•		233,074	233,074	7
8	V	31	AMORTIZATION			11	"	**	•		14,039	14,039	8
9	V		INTEREST			11	"	**	•		1,073,500	1,073,500	9
10	V		REAL ESTATE TAX EXPENSE			11	"	**	•		182,528	182,528	10
11	V	<b>26</b>	HAZARD INSURANCE			11	"	**	•		14,900	14,900	11
12	V								·				12
13	V												13
14	Total			\$ 1,560,00	00						\$ 1,540,549	\$ * (19,451)	14

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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### VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						<b>Average Hours Per Work</b>					
					Compensation	Week Dev	oted to this	Compensation Included		Schedule V.	
					Received	Facility and	l % of Total	in Costs	for this	Line &	
				Ownership	From Other	Work	Week	Reporting Period**		Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	BRUCE LEDERMAN	<b>ADMINISTRATOR</b>	ADMIN	47.50				SALARY	\$ 10,114	17-1	1
2	ALAN BURACK		MARKETING					SALARY	52,143	21-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 62,257		13

<sup>\*</sup> If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

<sup>\*\*</sup> This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.

ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

ST	ATE	OF	HI	JN	OI
91.	ALL	OI.		/III 7	v

Page 8 # 0039842 Report Period Beginning: **Facility Name & ID Number** CLAREMONT REHAB & LIVING CENTER 01/01/2002 Ending: 2/31/2002

### VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)  YES NO X	City / State / Zip Code	
	Phone Number	( )
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	( )

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•		3	\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11 12										11
13										12 13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										22
24										24
25	TOTALS					\$	\$		\$	25

**# 0039842** Report Period Beginning:

01/01/2002 Ending:

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# IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

**Facility Name & ID Number** 

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related YES		Purpose of Loan	Monthly Payment Required	Date of Note	Origi	Amount o	f Note Balance	Maturity Date	Interest Rate (4 Digits)	Reportin Period Interest Expense	
	A. Directly Facility Related				•							•	
	Long-Term												
1	PRUDENTIAL	$\Box$		MORTAGE			\$	\$	14,762,414			\$ 1,073,5	00 1
2													2
3													3
4													4
5													5
	Working Capital												
6	LASALLE BANK		X	LINE OF CREDIT	INTEREST				937,980		PRIME +	49,8	<b>67 6</b>
7													7
8													8
9	TOTAL Facility Related						\$	\$	15,700,394			\$ 1,123,3	67 9
10	B. Non-Facility Related*			T		1	l l		Ī				10
10 11		+ +											10 11
12		+ +											12
13		+ +											13
13													13
14	TOTAL Non-Facility Related						\$	\$				\$	14
15	TOTALS (line 9+line14)						\$	\$	15,700,394			\$ 1,123,3	67 15

<sup>16)</sup> Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line #

<sup>\*</sup> Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

<sup>\*\*</sup> If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Page 10 # 0039842 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued) **B.** Real Estate Taxes

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER

1. Real Estate Tax accrual used on 2001 report.	<i>Important</i> , please see the next worksheet, "RE_Tax". bill must accompany the cost report.	The real (	State tax statement and	•	1		
1. Real Estate Tax accidal used on 2001 report.	in the property of the propert			Φ			
2. Real Estate Taxes paid during the year: (Indicate the ta	x year to which this payment applies. If payment covers more than on	ne year, det	ail below.)	\$ 182,52	8 2		
2. Under or (ever) econol (line 2 minus line 1)				s 182,52	8 3		
3. Olider of (over) accrual (fille 2 fillings fille 1).	3. Under or (over) accrual (line 2 minus line 1).						
4. Real Estate Tax accrual used for 2002 report. (Detail a	and explain your calculation of this accrual on the lines below.)			\$	4		
5 Direct and a few and a f	5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.						
	s of invoices to support the cost and a copy of the ap			<b>s</b>	5		
		•	•				
6. Subtract a refund of real estate taxes. You must offset	the full amount of any direct appeal costs						
classified as a real estate tax cost plus one-half of any r	remaining refund.						
TOTAL REFUND \$ For	Tax Year. (Attach a copy of the real estate tax	x appeal	board's decision.)	\$	6		
7. Real Estate Tax expense reported on Schedule V, line 2	33. This should be a combination of lines 3 thru 6.			\$ 182,52	8 7		
Real Estate Tax History:							
Real Estate Tax History.							
Real Estate Tax Bill for Calendar Year: 1997	137,272 8		FOR OHF USE ONLY				
1998		12	FROM R. F. TAY OTATEMENT FOR	2 0004	12		
1999 2000	165,681 10 172,103 11	13	FROM R. E. TAX STATEMENT FOR	R 2001 \$	13		
2000	182,528 12	14	PLUS APPEAL COST FROM LINE 5	5 \$	14		
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL	IS BASED						
ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX	BILL	15	LESS REFUND FROM LINE 6	\$	15		
THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX	X BILL.	16	AMOUNT TO USE FOR RATE CAL	CULATION \$	16		

### **NOTES:**

- 1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

### IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

### 2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME CLAREMON	Г REHAB & LIVING CENTE	₹	COUNTY	LAKE	
FAC	ILITY IDPH LICENSE NUMBER	0039842				
CON	TACT PERSON REGARDING T	HIS REPORT BOB KAGDA				
TEL	EPHONE (847) 675-3585	FA	X#: (847)6	575-5777		
A.	Summary of Real Estate Tax C					
	Enter the tax index number and recost that applies to the operation home property which is vacant, reentered in Column D. Do not inc	of the nursing home in Column ented to other organizations, or	D. Real estate used for purpos	tax applicable to ses other than lo	o any portion	of the nursing
	(A)	(B)		(C)		(D)
	Tax Index Number	Property Description	<u>1</u>	Total Tax		Tax Applicable to Sursing Home
1.	15-33-404-140	NURSING HOME	\$	182,528.00	\$	182,528.00
2.			\$		\$	
3.			\$		\$	
4.						
5.						
6.						
7.			\$		\$	
8.						
9.			\$		\$	
10.					_ \$_	
		тот	TALS \$	182,528.00	s_	182,528.00
B.	Real Estate Tax Cost Allocation	<u>18</u>				
	Does any portion of the tax bill at used for nursing home services?		nome, vacant pro	operty, or prope	rty which is	not directly
	If YES, attach an explanation & a (Generally the real estate tax cost					iome.
C.	Tax Bills					
	Attach a copy of the 2001 tax bill is normally paid during 2002.	s which were listed in Section A	A to this statement	ent. Be sure to	use the 2001	tax bill which

Page 10A

Sacility Name & ID	Number CLADEMON	T DEHAD & LIVING CENTED		STATE OF		owied Deginnings	01/01/2002 Ending:	Page 11 12/31/2002
	D GENERAL INFORM	T REHAB & LIVING CENTER ATION:		#	0039642 Report F	eriod Beginning:	01/01/2002 Ending:	12/31/2002
A. Square Feet:	: 86,000	B. General Construction Type:	Exterior	BRICK	Frame	STEEL	Number of Stories	3
C. Does the Ope	erating Entity?	(a) Own the Facility	X (b) Rent from	a Related Or	ganization.		(c) Rent from Completely Uni Organization.	related
(Facilities ch	necking (a) or (b) must co	omplete Schedule XI. Those checking (	(c) may complete Schedu	ıle XI or Scho	edule XII-A. See inst	ructions.)		
D. Does the Ope	erating Entity?	X (a) Own the Equipment	(b) Rent equip	oment from a	Related Organization	n.	(c) Rent equipment from Con Unrelated Organization.	ıpletely
(Facilities ch	necking (a) or (b) must co	omplete Schedule XI-C. Those checkin	g (c) may complete Scho	edule XI-C or	Schedule XII-B. See	e instructions.)	Chromoto Organization.	
(such as, but	t not limited to, apartme	l by this operating entity or related to a nts, assisted living facilities, day traini quare footage, and number of beds/uni	ng facilities, day care, in	dependent liv				
	st report reflect any orga complete the following:	nnization or pre-operating costs which	are being amortized?			YES	NO NO	
1. Total Amount	t Incurred:			2. Number o	of Years Over Which	it is Being Amoi	rtized:	
3. Current Perio	od Amortization:			4. Dates Inc	urred:	224		
		Nature of Costs:	4-11 4b- 4-4-1	- <b></b>				
		(Attach a complete schedule de	taning the total amount	oi organizati	on and pre-operating	g costs.)		
XI. OWNERSHIP (	COSTS:		2		2			
A. Land.		Use 1 NURSING HOME	Square Feet		3 cquired 1994 \$	Cost 551,078	1	
		3 TOTALS			\$	551,078	3	

Page 12 12/31/2002 STATE OF ILLINOIS 0039842 **Report Period Beginning:** 01/01/2002 Ending:

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	ing Depreciation-including Fixed Equ	2	3	4	5	6	7	8	9	$\top$
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	ŀ
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	ŀ
4	200		1994	1994	\$ 8,490,995	\$ 212,670	39	<b>\$</b> 217,718	\$ 5,048	\$ 1,841,400	4
5											5
6											6
7											7
8											8
	Impro	ovement Type**									
9	EXTERIOR S	SIGN		1995	3,113	80	15	80		550	9
10	NURSING ST	TATION		1995	2,634	68	39	68		456	10
	CONDENSO			1995	11,363	291	39	291		1,855	11
	SODING, PL			1995	1,350	35	39	35		217	12
	REPLACE S			1995	2,732	70	39	70		429	13
	INSTALLED			1995	1,651	42	39	42		254	14
_	INSTALLED	CIRCUITS		1996	2,360	61	39	61		318	15
_	SHRUBS			1996	5,480	366	15	366		2,012	16
		RE DAMPERS		1997	11,500	295	39	295		1,315	17
	LEAD SHOW			1997	6,875	176	39	176		726	18
	HEATER RE	PAIR		1997	20,316	521	39	521		2,149	19
	TILE			1997	4,890	125	39	125		505	20
	CERAMIC T			1998	7,335	188	39	188		745	21
	CARPETING WALL REPA			1998 1998	25,777 53,734	661 1,378	39	661 1,378		2,452 4,398	22
	EXIT SIGNS			1998	1,860	1,378	39	1,578		154	23
		IDEWALK, ASPHALT SEALING		1998	8,147	543	15	543		1.900	25
	LANDSCAPI	, and a second s		1998	22,400	1,494	15	1,494		5,228	26
		LAYGROUND EQUIPMENT		1998	32,800	2,188	15	2,188		7,656	27
	ELEVATOR			1999	43,763	1,122	39	1,122		2,572	28
	SIDEWALK	THE PROPERTY OF THE PROPERTY O		1999	4,900	327	15	327		817	29
		SENSOR/OUTLETS		2000	45,308	1,647	27.5	1,647		3,226	30
	ELEVATOR			2000	62,821	2,284	27.5	2,284		2,936	31
		AIR/SHOWER DRAIN REPAIR		2001	4,100	149	27.5	149		287	32
_	HVAC/UNIT			2001	20,061	729	27.5	729		900	33
	HOT WATE			2001	36,873	1,341	27.5	1,341		2,136	34
		ALYSIS ROOM		2001	59,646	2,169	27.5	2,169		3,355	35
36								,		· · · · · · · · · · · · · · · · · · ·	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

0039842

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar,

B. Building Depreciation-Including Fixed Equipment. (See inst	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37 DINING ROOM FLOOR	2002	<b>\$</b> 11,024	\$ 4,352	20	\$ 551	\$ (3,801)	\$ 551	37
38 CARPET	2002	17,849	8,352	20	892	(7,460)	892	38
39 ELEVATOR FLOOR	2002	1,000	36	27.5	36		36	39
40 DIALYSIS BOOSTER PUMPS	2002	5,132	187	27.5	187		187	40
41 HEATING & A/C REPAIR	2002	1,300	52	27.5	52		52	41
42 PUMP PIT & DUCT REPAIR	2002	18,750	682	27.5	682		682	42
43 CONCRETE WATERPROOFING	2002	8,920	324	27.5	324		324	43
44 PLUMBING WORK - LAUNDRY ROOM	2002	39,507	1,437	27.5	1,437		1,437	44
45								45
46								46
47								47
48 49								48
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 9,098,266	\$ 246,490		\$ 240,277	\$ (6,213)	\$ 1,895,109	70

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS Page 13 **Report Period Beginning:** 01/01/2002 Ending: 12/31/2002 # 0039842

**Facility Name & ID Number** XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

**CLAREMONT REHAB & LIVING CENTER** 

	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 526,586	\$ 66,037	\$ 51,573	\$ (14,464)	8/15 yrs	\$ 240,337	71
72	<b>Current Year Purchases</b>	19,873	8,744	994	(7,750)	10 years	4,501	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	1,313,061	20,404	131,306	110,902	10 years	1,037,953	74
75	TOTALS	\$ 1,859,520	\$ 95,185	\$ 183,873	\$ 88,688		\$ 1,282,791	75

D. Vehicle Depreciation (See instructions.)\*

						~	_	T 40 4		$\overline{}$
	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76		FORD VAN	1998	\$ 16,033	\$ 1,847	\$ 3,207	\$ 1,360	5	\$ 16,082	76
77										77
78										78
79										79
80	TOTALS			\$ 16,033	\$ 1,847	\$ 3,207	\$ 1,360		\$ 16,082	80

	E. Summary of Care-Related Assets	1	2		
		Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,524,897	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 343,522	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 427,357	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 83,835	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,193,982	85	1

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

- Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.
- This must agree with Schedule V line 30, column 8.

raciii	y Name & 1D Number	CLAREMONT REHAB & LIVING CENTER	#	0039842	Report Period
XII. R	ENTAL COSTS				
1	A. Building and Fixed Equipn	nent (See instructions.)			
	1. Name of Party Holding Le	ase: NA			
	2. Does the facility also pay r	eal estate taxes in addition to rental amount shown bel	ow on line 7, o	column 4?	
	If NO, see instructions.		,	YES N	0

		1	2	3	4	5	6	
		Year	Number	Date of	Rental	Total Years	Total Years	
		Constructed	of Beds	Lease	Amount	of Lease	Renewal Option*	
	Original							
3	<b>Building:</b>				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any	y amortizatioi	of lease	expense inc	luded o	** on page 4, line 34.		 F	iscal Year	r Ending
This amount was	calculated by	dividing t	he total ame	ount to	be amortized				_
by the length of th	ie lease		•				12.		/2
							13.		/2
9. Option to Buy:		YES		NO	Terms:	*	14.		/2
R Fauinment Evelud	ing Transpar	tation and	l Fived Fan	inmont	(See instructions)			'	

12.	/2003	\$
13.	/2004	\$ 
l <b>4.</b>	/2005	\$

**Annual Rent** 

11. Rent to be paid in future years under the current

10. Effective dates of current rental agreement:

Beginning **Ending** 

rental agreement:

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Mo	vable equipmen	t rental included in building rental?	

15. Is Movable equipment rental included in	buildi	ing rental?	,	YES	NO
16. Rental Amount for movable equipment:	\$	13,725	Description:	<b>SEE SCHEDULE</b>	E ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1	2	3	4	
		Model Year	Monthly Lease	Rental Expense	
	Use	and Make	Payment	for this Period	
17	PATIENTS	99-14-PASSNGR BUS	\$ 899.00	\$ 10,909	17
18					18
19	ADMINISTRATOR	99-HONDA ACCORD	329.00	2,004	19
20		98-HONDA ACCORD		6,343	20
21	TOTAL		\$ 1,228.00	\$ 19,256	21

<sup>\*</sup> If there is an option to buy the building, please provide complete details on attached schedule.

<sup>\*\*</sup> This amount plus any amortization of lease expense must agree with page 4, line 34.

0039842

**Report Period Beginning:** 

01/01/2002 Ending:

12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

1. HAVE YOU TRAINED AIDES	YES	2.	CLASSROOM PORTION:	 3.	CLINICAL PORTION:	
DURING THIS REPORT PERIOD?	X NO		IN-HOUSE PROGRAM		IN-HOUSE PROGRAM	
If the set of the second secon			IN OTHER FACILITY		IN OTHER FACILITY	
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was			COMMUNITY COLLEGE		HOURS PER AIDE	
not necessary.			HOURS PER AIDE			

### **B. EXPENSES**

### ALLOCATION OF COSTS (d)

1 2 3 4

		Fa	cility		
		Drop-outs	Completed	Contract	Total
	Community College Tuition	\$	\$	\$	\$
	Books and Supplies				
	Classroom Wages (a)				
	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
	Transportation				
	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

### C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

3		

### D. NUMBER OF AIDES TRAINED

COMDI ETED	
COMPLETED  1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility 2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

4,907

409,005

14 TOTAL

413,912

14

3 Schedule V Staff **Outside Practitioner** Supplies (Actual or) Line & Column Units of Cost (other than consultant) **Total Cost** Service **Total Units** Reference Service Units Cost Allocated) (Column 2+4) (Col. 3 + 5 + 6)**Licensed Occupational Therapist** hrs **Licensed Speech and Language** 4,317 2 **Development Therapist 39-3** 4,317 hrs 2 **Licensed Recreational Therapist** 3 hrs 39-3 **590 Licensed Physical Therapist** hrs 590 4 Physician Care 5 visits **Dental Care** 6 visits Work Related Program 7 hrs Habilitation hrs 8 # of 346,476 Pharmacy 39-2 prescrpts 346,476 **Psychological Services** (Evaluation and Diagnosis/ **Behavior Modification)** hrs 10 **Academic Education** 11 hrs 12 Exceptional Care Program 12 39-2 & 3 62,529 13 Other (specify): Rentals 62,529 13

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS Page 17
# 0039842 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER

XV RALANCE SHEET - Unrestricted Operating Fund

As of 12/31/2002 (last day of reporting year)

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

	This report must be completed even	1 1	inciai statemen	2 After	
		o	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	199,411	\$	1
2	Cash-Patient Deposits				2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance )		2,658,891		3
4	Supply Inventory (priced at )				4
5	Short-Term Investments				5
6	Prepaid Insurance		122,739		6
7	Other Prepaid Expenses		201,623		7
8	Accounts Receivable (owners or related parties)		545,605		8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	3,728,269	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land				13
14	Buildings, at Historical Cost				14
15	Leasehold Improvements, at Historical Cost		607,271		15
16	Equipment, at Historical Cost		562,492		16
17	Accumulated Depreciation (book methods)		(542,180)		17
18	Deferred Charges		30,025		18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify):				23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	657,608	\$	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	4,385,877	\$	25

		1 0	perating	2 Aft Consoli	er idation*	
	C. Current Liabilities					
26	Accounts Payable	\$	1,989,128	\$		26
27	Officer's Accounts Payable					27
28	Accounts Payable-Patient Deposits					28
29	Short-Term Notes Payable		521,313			29
30	Accrued Salaries Payable		239,935			30
	Accrued Taxes Payable					
31	(excluding real estate taxes)		25,449			31
32	Accrued Real Estate Taxes(Sch.IX-B)					32
33	Accrued Interest Payable		2,801			33
34	Deferred Compensation					34
35	Federal and State Income Taxes					35
	Other Current Liabilities(specify):					
36						36
37						37
	TOTAL Current Liabilities					
38	(sum of lines 26 thru 37)	\$	2,778,626	\$		38
	D. Long-Term Liabilities					
39	Long-Term Notes Payable		651,263			39
40	Mortgage Payable					40
41	Bonds Payable					41
42	Deferred Compensation					42
	Other Long-Term Liabilities(specify):					
43						43
44						44
	TOTAL Long-Term Liabilities					
45	(sum of lines 39 thru 44)	\$	651,263	\$		45
	TOTAL LIABILITIES					Ī
46	(sum of lines 38 and 45)	\$	3,429,889	\$		46
47	TOTAL EQUITY(page 18, line 24)	\$	955,988	\$		47
	TOTAL LIABILITIES AND EQUITY		- /			1
48	(sum of lines 46 and 47)	\$	4,385,877	\$		48

\*(See instructions.)

0039842

**Report Period Beginning: 01/01/2002** 

Page 18 12/31/2002 Ending:

Total Balance at Beginning of Year, as Previously Reported 1,555,010 Restatements (describe): 2 3 3 4 5 Balance at Beginning of Year, as Restated (sum of lines 1-5) 1,555,010 A. Additions (deductions): NET Income (Loss) (from page 19, line 43) (599,022)**8** Aguisitions of Pooled Companies 8 Proceeds from Sale of Stock 9 10 Stock Options Exercised 10 11 Contributions and Grants 11 12 Expenditures for Specific Purposes 12 13 Dividends Paid or Other Distributions to Owners 13 14 Donated Property, Plant, and Equipment 14 15 15 Other (describe) 16 Other (describe) 16 17 17 TOTAL Additions (deductions) (sum of lines 7-16) (599,022)B. Transfers (Itemize): 18 18 19 19 20 21 22 23 23 TOTAL Transfers (sum of lines 18-22) 24 24 BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23) 955,988

<sup>\*</sup> This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

			1	
	Revenue		Amount	
	A. Inpatient Care			
1	Gross Revenue All Levels of Care	\$	9,002,184	1
2	Discounts and Allowances for all Levels	(	)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	9,002,184	3
	B. Ancillary Revenue			
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy		305,213	6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	305,213	8
	C. Other Operating Revenue			
9	Payments for Education			9
10	Other Government Grants			10
11	Nurses Aide Training Reimbursements			11
	Gift and Coffee Shop		2,105	12
13	Barber and Beauty Care		(2,989)	13
14	Non-Patient Meals		15,276	14
15	Telephone, Television and Radio			15
	Rental of Facility Space		2,081	16
17	Sale of Drugs			17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray			20
21	Other Medical Services			21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	16,473	23
	D. Non-Operating Revenue			
24	Contributions			24
25	Interest and Other Investment Income***		3,140	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	3,140	26
	E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)			27
28	Vending Commissions		846	28
28a	Insurance Claim		9,380	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	10,226	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	9,337,236	30

	io against expenses	2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,515,624	31
32	Health Care	4,471,340	32
33	General Administration	1,672,586	33
	B. Capital Expense		
34	Ownership	1,753,296	34
	C. Ancillary Expense		
35	Special Cost Centers	413,912	35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,936,258	40
41	Income before Income Taxes (line 30 minus line 40)**	(599,022)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (599,022)	43

*	This must	agree w	ith page	4, line 4	5, column 4.
^	i nis musi	agree w	atn page	4, line 4	5, coiun

**	Does this agree with taxable in	ncome (loss) per Federal Income
	Tax Return?	If not, please attach a reconciliation

See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

<sup>\*\*\*\*</sup>Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER

# 0039842 Report Period Beginning:

01/01/2002

Ending:

12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

1 2\*\*

2\*\* 3

		1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	1,896	2,059	\$ 67,917	\$ 32.99	1
2	Assistant Director of Nursing	2,752	3,027	63,510	20.98	2
3	Registered Nurses	34,428	36,424	944,865	25.94	3
4	Licensed Practical Nurses	12,610	13,533	277,923	20.54	4
5	Nurse Aides & Orderlies	115,350	124,447	1,381,753	11.10	5
6	Nurse Aide Trainees	ĺ	Í	, i		6
7	Licensed Therapist	15,380	17,150	455,110	26.54	7
8	Rehab/Therapy Aides	9,535	10,726	139,139	12.97	8
9	Activity Director					9
10	Activity Assistants	12,781	13,504	147,592	10.93	10
11	Social Service Workers	2,961	3,254	45,252	13.91	11
12	Dietician					12
13	Food Service Supervisor	4,080	4,668	84,815	18.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,082	32,503	275,202	8.47	15
16	Dishwashers					16
17	Maintenance Workers	4,617	4,994	76,112	15.24	17
	Housekeepers	27,752	29,035	224,542	7.73	18
19	Laundry	8,211	8,900	63,613	7.15	19
20	Administrator	2,320	2,520	105,719	41.95	20
21	Assistant Administrator	425	438	3,608	8.24	21
22	Other Administrative	656	720	27,190	37.76	22
23	Office Manager					23
24	Clerical	14,544	15,658	255,475	16.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,968	4,250	56,066	13.19	31
32	Other Health Care(specify)					32
33	Other(specify)	12,363	13,059	293,218	22.45	33
34	TOTAL (lines 1 - 33)	317,711	340,869	\$ 4,988,621 *	\$ 14.64	34

<sup>\*</sup> This total must agree with page 4, column 1, line 45.

### B. CONSULTANT SERVICES

		1	2	3	
		Number	<b>Total Consultant</b>	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	M	<b>\$</b> 13,321	1-3	35
36	Medical Director	0	56,250	9-3	36
37	Medical Records Consultant	N	4,128	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,400	10-3	39
40	Physical Therapy Consultant	L	495	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	7,166	12-3	45
46	Other(specify)	S			46
47	PSYCHO-SOCIAL CONSULTANT		7,613	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 91,373		49

### C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses	1,854	\$ 88,992	10-3	50
51	Licensed Practical Nurses	2,316	74,141	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	4,170	\$ 163,133		53

<sup>\*\*</sup> See instructions.

STATE OF ILLINOIS Page 21 Facility Name & ID Number
XIX. SUPPORT SCHEDULES **Report Period Beginning:** 01/01/2002 Ending: 12/31/2002

CLAREMONT REHAB & LIVING CENTER # 0039842

A. Administrative Salaries		Ownership	)		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotion	ons	
Name	Function	%		Amount	Description		Amount	Description		Amount
BRUCE LEDERMAN	ADMIN	47.50	\$	10,114	Workers' Compensation Insurance	\$	71,627	IDPH License Fee	\$	150
LARRY PUTZ	ADMIN	0.00		95,605	<b>Unemployment Compensation Insurance</b>		48,994	Advertising: Employee Recruitment		18,703
LIZ SHAPIRO	ASST ADMIN	0.00		2,204	FICA Taxes		370,525	<b>Health Care Worker Background Check</b>		1,956
M DEPPEN	ASST ADMIN	0		1,404	<b>Employee Health Insurance</b>		88,846	(Indicate # of checks performed)	, –	,
					<b>Employee Meals</b>		#REF!	MARKETING/ADV/PROMO		70,305
OTHER ADMINISTRATIVE		0		27,190	Illinois Municipal Retirement Fund (IMRF)	*		TRUST/FRANCHISE/CONTRIB/ETC		5,250
					EMPLOYEE BENEFITS - OTHER		2,779	LICENSES & PERMITS		250
TOTAL (agree to Schedule V, line	17, col. 1)		_		EMPLOYEE PHYSICAL EXAMS		850	DUES & SUBSCRIPTIONS		20,675
(List each licensed administrator se			\$	136,517	PENSION/PROFIT SHARING PLANS		0		_	
B. Administrative - Other			_		CHICAGO HEAD TAX	_	0	TRUST/FRANCHISE/CONTRIB/ETC	_	(5,250)
					INSURANCE - EXECUTIVE LIFE	_	(2,747)	Less: Public Relations Expense	( -	0
Description				Amount		_		Non-allowable advertising	` _	(62,360)
•			\$	0	INSURANCE - EXECUTIVE LIFE V	<u>I</u> 21		Yellow page advertising	_	(7,945)
			_		TOTAL (agree to Schedule V, line 22, col.8)	\$	#REF!	TOTAL (agree to Sch. V, line 20, col. 8)	\$_	41,734
TOTAL (agree to Schedule V, line	17. col. 3)		<u>s</u> -	0	E. Schedule of Non-Cash Compensation Paid	d		G. Schedule of Travel and Seminar**		
(Attach a copy of any management		t)		<u> </u>	to Owners or Employees	-				
C. Professional Services	ser vice agreemen							Description		Amount
Vendor/Payee	Type			Amount	Description Line #		Amount	Description		111104114
, chaon a ujec			\$_		Zeseription Zime ii	_ \$		Out-of-State Travel	\$_	
			_			_		In-State Travel	_	
			_			<u> </u>			_	0
			-			_		Seminar Expense	_	
			_			_			_	0
SEE SCHEDULE ATTACHED	10 1 2		_	247,462	ТОТА	_		Entertainment Expense	( _	
TOTAL (agree to Schedule V, line (If total legal fees exceed \$2500 atta		es.)	\$_	247,462	TOTAL	\$		(agree to Sch. V, TOTAL line 24, col. 8)	\$	0

<sup>\*</sup> Attach copy of IMRF notifications

<sup>\*\*</sup>See instructions.

Report Period Beginning: 01/01/2002

**Ending:** 

Page 22 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

1 3 6 7 10 11 12 13 Month & Year **Amount of Expense Amortized Per Year Improvement Improvement Total Cost** Useful FY1999 FY2000 FY2001 FY2002 FY2003 FY2004 FY2005 FY2006 FY2007 Type Was Made Life \$ 1,775 PAINTING/DECORATIN 2000 5,325 **887** \$ 1,775 888 PAINTING/DECORATIN 2001 7,721 1,287 2,574 2,574 1,286 3 5 6 8 9 10 11 12 13 14 15 16 17 18 19 20 **TOTALS** 13,046 887 3,062 4,349 3,462 1,286

	y Name & ID Number CLAREMONT REHAB & LIVING CENTER	#	0039842	Report Period Beginning:	01/01/2002	<b>Ending:</b>	12/31/2002
	ENERAL INFORMATION:						
(1)	Are nursing employees (RN,LPN,NA) represented by a union?  NO	(13)		plies and services which are of the blic Aid, in addition to the daily r			
(2)	Are there any dues to nursing home associations included on the cost report? YES  If YES, give association name and amount. ILL COUNC ON LONG TERM CARE \$11900		in the Ancillary Section	on of Schedule V? YES	_		
(3)	Did the nursing home make political contributions or payments to a political action organization?  YES  If YES, have these costs been properly adjusted out of the cost report?  YES	(14)	the patient census liste is a portion of the buil	lding used for any function other ed on page 2, Section B? NO dding used for rental, a pharmacy lains how all related costs were a	, day care, etc.)	For example If YES, attack	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?	(15)	Indicate the cost of er on Schedule V. related costs?		assified to employ meal income be the amount. \$		ainst
(5)	Have you properly capitalized all major repairs and equipment purchases?  What was the average life used for new equipment added during this period?  YES  10 YR	(16)	Travel and Transporta	ution uded for out-of-state travel?	NO		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 41 Line 10-2		If YES, attach a con		at to provide med	dical transpor	rtation for
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?  YES  If NO, attach a complete explanation.		program during this c. What percent of all				
(8)	Are you presently operating under a sale and leaseback arrangement?  If YES, give effective date of lease.		e. Are all vehicles sto times when not in u	red at the nursing home during th			
(9)	Are you presently operating under a sublease agreement? YES X NO		out of the cost repo		2		NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.		Indicate the amo	ount of income earned from puring this reporting period.	providing sucl \$	1 	
		(17)	Has an audit been per Firm Name:	formed by an independent certific	ed public accour		NO tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 109,500  This amount is to be recorded on line 42 of Schedule V.		cost report require that been attached?	t a copy of this audit be included  If no, please explain.	with the cost re	port. Has thi	s copy
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  NO If YES, attach an explanation of the allocation.		out of Schedule V?	do not relate to the provision of lo		•	
		(19)	performed been attack	n excess of \$2500, have legal invested to this cost report?  Summary of services for all archives.			rices

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	Facility Name & ID#: CLAREMONT REHA			<del>#</del> 0039842	Report Period Beginning: 01/01/2002	Ending:	12/31/2002
	V.COST CENTER EXPENSES PAGE 3 C		ER				
NE	SCHED R	<u>EF</u>	TOTAL	LINE			TOTAL
1	DIETARY			10	NURSING		
	DIETITIAN CONSULTANT XVIII B 35	-2 13,321			CONTRACT NURSING XVIII C 53-2	163,133	_
	REPAIRS & MAINTENANCE	9,520			LABORATORY & XRAY EXPENSE	36,480	_
		0	22,841		PURCHASED SERVICES	0	
3	HOUSEKEEPING				PSYCHO-SOCIAL CONSULTANT XVIII B2	7,613	
		0			RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0	
		0	0		MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,128	
4	LAUNDRY				PHARMACY CONSULTANT XVIII B 39-2	2,400	
	<b>EQUIPMENT REPAIRS &amp; MAINTENANCI</b>	<b>924</b>			PROGRAM CONSULTANT XVIII B2	45,807	
		0	924		PHYSICIANS XVIII B2	0	
5	HEAT & OTHER UTILITIES				PSYCHIATRIC XVIII B2	0	
	GAS HEAT	84,086			RN CONSULTANT XVIII B 38-2	0	
	ELECTRICITY	109,296				0	
	WATER	19,890				0	259,56
	CABLE TV - LOBBY	5,926		10a	THERAPY		
		0	219,198		PHYSICAL THERAPY SERVICES	0	
6	MAINTENANCE				SPEECH THERAPY SERVICES	0	
	GROUNDS MAINTENANCE	14,663			OCCUPATIONAL THERAPY SERVICES	0	
	PAINTING & DECORATING	12,583			REHABILITATION CONSULTANT XVIII B2	0	
	BUILDING REPAIRS	459			PHYSICAL THERAPY CONSULTANT XVIII B 40-2	495	
	MAINTENANCE TRAVEL				OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0	1
	EQUIPMENT MAINTENANCE & REPAIR	71,757			RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0	1
	ELEVATOR MAINTENANCE & REPAIR	9,348			SPEECH THERAPY CONSULTANT XVIII B 43-2	0	49
	OUTSIDE LABOR	0		11	ACTIVITIES		
	EXTERMINATING SERVICE	1,124			CABLE TV - PATIENT ROOMS	0	1
	FIRE SERVICE	4,112			ACTIVITY REHAB CONSULTANT XVIII B 44-2	0	1
		0			CLERGY	44,808	44,80
		0		12	SOCIAL SERVICES		
		0	114,046		SOCIAL REHABILITATION SERVICES	0	1
7	OTHER				SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0	1
	SCAVENGER	19,094			SOCIAL WORKER XVIII B 45-2	7,166	1
	SECURITY SERVICE	387	19,481			0	
9	MEDICAL DIRECTOR		·	13	NURSE AIDE TRAINING		
	MEDICAL DIRECTOR FEES XVIII B 36	-2 56,250	56,250		NURSE AIDE TRAINING COSTS XIII	0	(

	Facility Name & ID Number CLAREMONT REHAB & LIVING	CENTER	#	0039842	Report Period Beginning: 01/01/2002	Ending:	12/31/2002	
	V.COST CENTER EXPENSES PAGE 3 C	OLUMN 3 OTH	ER				_	
LINE	SCHED R	F	TOTAL	LINI	ESCHED R	F	TOTAL	
14	PROGRAM TRANSPORTATION			22	EMPLOYEE BENEFITS & PAYROLL TAXES			
	PATIENT TRANSPORTATION	1,091	1,091		FICA TAXES XIX	D 370,525		
					UNEMPLOYMENT COMPENSATION XIX	D 48,994		
17	ADMINISTRATIVE				WORKERS COMPENSATION INSURANC XIX	D 71,627		
	MANAGEMENT FEES XIX	В 0	0		HOSPITALIZATION INSURANCE XIX	D 88,846		
18	DIRECTORS FEES	0	0		EMPLOYEE BENEFITS - OTHER XIX	D 2,779		
19	PROFESSIONAL SERVICES				EMPLOYEE PHYSICAL EXAMS XIX	D 850		
	DATA PROCESSING XIX	C 29,330			INSURANCE - EXECUTIVE LIFE VI 21/XIX	D 0		
	ADMINISTRATIVE CONSULTANTS XIX	C 0			PENSION/PROFIT SHARING PLANS XIX	D 0		
	PROFESSIONAL FEES XIX	C 218,132			CHICAGO HEAD TAX XIX	D 0	583,621	
		0	247,462	23	INSERVICE TRAINING & EDUCATION			
20	FEES,SUBSCRIPTIONS,PROMOTIONS		i		EDUCATION & SEMINARS	6,861	6,861	
	ENTERTAINMENT & MARKETING VI 19 XIX	F 0						
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX	F 62,360		24	TRAVEL & SEMINARS			
	EMPLOYEE WANT ADS XIX	F 18,703			EDUCATION & SEMINARS XIX	G 0		
	CONTRIBUTIONS VI 20 XIX	F 5,000			TRAVEL XIX	G 0		
	DUES & SUBSCRIPTIONS XIX	F 20,675				0		
	LICENSES & PERMITS XIX	F 400				0	0	
	PUBLIC RELATIONS-PATIENT RELATED XIX	F 0		25	ADMIN. STAFF TRANSPORTATION			
	ADVERTISING-YELLOW PAGES VI 28 XIX	F 7,945			TRANSPORTATION - STAFF	4,309	4,309	
	FRANCHISE TAX VI 17 XIX	F 250						
	CONTRIBUTIONS - POLITICAL VI 20 XIX	F 0		26	INSURANCE - PROP. LIAB & MALPRACTICE			
	HEALTH CARE WORKER BACKGROUND CHEC XIX	F 1,956	117,289		GENERAL INSURANCE	131,227	131,227	
21	CLERICAL & GENERAL OFFICE EXPENSES							
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES	) 0		27	OTHER			
	EQUIPMENT REPAIR & MAINTENANCE	12,014			BAD DEBTS VI	<b>74,389</b>		
	OUTSIDE CLERICAL SERVICES	0				0	74,389	
	PENALTIES / OVERDRAFT CHARGES VI	18 0						
	HOME OFFICE EXPENSE	0						
	THEFT & DAMAGE LOSS	11,262						
	TELEPHONE	40,642			GRAND TOTAL COLUMN 3 OTHER		1,990,630	
	MESSENGER SERVICE	0						
	COMPUTER MAINTENANCE	15,693	79,611					